REPORT OF

MID TERM EVALUATION OF THE CONGREGATION BASED PRIMARY HEALTH CARE PROGRAM PHASE III (2011-2015)

A project of
Mohulpahari Christian Hospital
Dumka, Jharkhand

Supported by Normisjon

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LIST OF ABBREVIATIONS:

AIDP	Agriculture Integrated Development Project
AIDS	Acquired Immune Deficiency Syndrome
ANM	Auxiliary Nursing Midwife
CBO	Community Based Organizations
CBPHCP	Congregation Based Primary Health Care Project
CEO	Chief Executive Officer
CHV	Community Health Volunteer
CNT	Chota Nagpur Tenancy act
ESAF	Evangelical Social Action Forum
GNM	General Nursing and Midwife
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Scheme
IEC	Information Education Communication
IGP	Income Generating Program
LEO	Lady Extension Officer
M&E	Monitoring and Evaluation
MCH	Mohulpahari Christian Hospital
MCHDP	Mohulpahari Christian Hospital Development Project
MIS	Management Information System
MS	Medical Superintendent
NELC	Northern Evangelical Lutheran Church
NGO	Non- Government Organization
NRHM	National Rural Health Mission (NRHM
PHC	Primary Health Center
PME	Planning, Monitoring and Evaluation
PRA	Participatory Rural Appraisal
PRI	Panchayati Raj Institution
RD	Rural Development
RS	Recording Studio
RSBY	RashtriyaSwasthyaBimaYojna
RTI	Right to Information
SHG	Self Help Group
SPT	SanthalPargana Tenancy act
STI	Sexually Transmitted Infections
TOT	Training of Trainers

CONTENT

Annexure

EXECUTIVE SUMMARY

Congregation Based Primary Health Care Project (CBPHCP) is an initiative of Mohulpahari Christian Hospital (MCH) situated in Dumka district of Jharkhand 45% people are of Santhal or Paharia tribes and 6% belong to schedule caste groups. CBPHCP translates the healing ministry of Northern Evangelical Lutheran Church (NELC) bringing congregations to the center stage in responding to the need of the local community. The project is now in its third phase and though the focus was to improve access to health care, it has also responded to the development needs by organizing women, capacity building, economic activities, improving agriculture and by addressing rights issues. Being integral part of MCH it has continued to develop systems and community processes to improve people's access to quality health care in MCH. At the same time the project is constantly working towards building awareness of health and development related government programs and works with the community for better access.

Major findings

Partnerships:
CBPHCP has worked with Recording Studio (RS) of NELC to develop and broadcast Santhali language programs on HIV/AIDS and other important health issues. In the third phase Rural Development (RD) society of NELC also joined hands in bringing inputs for improving agriculture practices and input towards sustainable eco-system. This is a unique partnership where expertise in different fields and management experience are working together with potential for cross learning among partners and holistic input to the community.

Organizational design:
Congregations are the heart of any church and bringing them into a project working towards empowerment is a unique effort. This is a blessing as well as challenge for the project as congregations themselves need empowerment to address issues not traditionally considered part of their mandate. Ownership by NELC has ensured participation of church leaders in project management but the monitoring role is a challenge. The existing committees have not been able to facilitate needed delegation and accountability at different levels probably due to lack of clarity of roles and to some extent management style of NELC.

MCH is the Implementing NELC organization for CBPHCP consequently requiring the project to follow the administrative system of MCH. Needed modifications in the administrative systems of MCH for the implementation of a community program in more than 150 villages is inadequate. In addition delegation of MCH and CBPHCP responsibilities to full time field staff for the success such a project is not adequate.

Impact of Strategies:
The impact of CBPCHP visible now should be attributed to the input from phase I onwards which is about ten years of different levels of input. There is a visible change and empowerment of women who are part of organized women's groups, the SHGs.. Many women who are or have been part of SHGs have gone on to take leadership role in the local self-

government (Panchayati Raj Institution or PRI) system. Many are politically active and are in positions of influence.

Many groups have taken up collective economic activities and are accessing government schemes and programs. Agricultural inputs by RD are greatly appreciated and have definite economic benefit. Adaptation by farmers is limited and not sustained raising question on long term contribution to income enhancement. All families linked to active women groups have better income as they are involved in some Income Generating Program (IGP) and many have accessed bank credit schemes. Substantial change in income has led to reduction or elimination of livelihood related migration in few villages. The successful SHG are characterized by a strong leader and good family support. Social participation and participation in PRI activities by the women is good probably due to higher level of awareness about rights and overall empowerment. However, examples of visible social action are few.

Overall access to health has improved due to recent government initiative Poor are able to get care in Mohulpahari Christian Hospital due to combined effort by project based referral, subsidized care by MCH and Government Insurance Scheme. Reportedly the services such as antenatal care, immunization and safe delivery care are widely available and well used. Specific contribution of CBPHCP in the area of health is difficult to ascertain due to lack of a robust monitoring system. Menace of alcohol, a felt need in the community and water and sanitation issues are not yet brought into the focus.

New dimension:

Inputs towards locally sustainable livelihood through agricultural and eco-system preservation methods were brought in by RD. This is a valuable contribution in communities where livelihood options are few and migration is common. Adaptation of new ideas presented will require more focused planning, more community participation in deciding on inputs, hand-holding and documentation of change by users/ beneficiaries. RD needs to consider business plans for some of the bio-based farm inputs promoted by them.

Rights awareness and rights-based action is a real challenge for tribal groups though Santhal tribe has not been docile. There is much to do and the start with organized groups and PRI is good.

Lessons learnt and recommendation:

Sustained input for over ten years by CBPHCP is showing definite empowerment of communities especially members of SHGs. With health services fast improving with a better functioning public health system, the role of CBPHCP is changing to address other needs which have more social dimensions such as alcoholism, water and sanitation, and livelihood. These cannot be fully addressed without addressing the issue of rights and entitlements, and CBPHCP is moving in the right direction.

However, to be able to respond to the challenge and be relevant, MCH and NELC need to ensure good governance and management systems in all projects. CBPHCP needs to review the

project document in the light of current community needs, decide on priorities for remaining project period and develop an implementation plan aligned with project vision. There is a need to develop competency of personnel at different level to achieve this.

1. INTRODUCTION

1.1 NORTHERN EVANGELICAL LUTHERAN CHURCH- - Northern Evangelical Lutheran Church (NELC) was founded in 1868 by Danish and Norwegian missionaries in Santhal Parganas. The membership comprises of Santhal, Boro and Bengali people and it has presence in four northern and north-eastern states in India. The central office is located in Dumka, Jharkhand which also is the center for educational and evangelistic activities of the church.

The church has longstanding relationship with national and international Lutheran organizations to address socio-developmental needs of local tribal people.

NELC Church Bandorjuri, Dumka

1.2 NORMISJON- Normisjon is an association of three missionary organizations in Norway. Of these the Norwegian Santhal Mission was the mother mission to Northern Evangelical Lutheran Church (renamed in 1958). It works in large number of countries with the vision of bringing Jesus Christ to future generations and Nations. NELC has been supported by Normisjon as a partner in building the capacity of the church to administer and manage many institutions and projects. Specific need based projects have been developed and supported by Normisjon.

1.3 MOHULPAHARI CHRISTIAN HOSPITAL AND CONGREGATION BASED PRIMARY HEALTH CARE PROGRAM-

Mohulpahari Christian Hospital is the largest hospital owned by NELC. It has 130 beds providing general specialty health care and specialized surgical care. It also runs a school of nursing offering general nursing (GNM) and auxiliary nurse midwife (ANM) courses. The hospital moved from Bengaria, a more remote village, to Mohulpahari in 1951 to make it more accessible to the people. It has responded to challenges due to change in health care sector in India by reorienting the hospital's relationship with its clientele. MCH went through a specific project for revitalization and refining of management process starting in the year 1999. The project used the experience of Emmanuel Hospital Association and was additionally supported by Christian Medical Association of India. This project also addressed human resource needs and as a response to the local need initiated the Congregation Based Primary Health Care Project (CBPHCP). The CBPHCP developed to address the existing needs in the local communities and used an innovative strategy involving the congregation to respond to health and development needs. This project was supported by Normisjon. After the MCH Development

Project ended, CBPHCP continued in its second phase that ended in 2009. The third phase of CBPHCP started in 2011. This phase of the project diversified and has partnered with two NELC organizations to strengthen the project.

1.4 PROJECT CONTEXT:

The project is spread in parts of three community development blocks of Dumka districts, namely Dumka, Shikaripara and Raniswar. The area is geographically contiguous and covers villages belonging to thirteen congregation of NELC and one congregation of the Catholic church. The choice of village was influenced by the location and jurisdiction of the congregations rather than the government administrative structure. The project is expected to work in 140 villages and approximately among 57,000 people.

Santhal tribe is the largest tribe in Jharkhand and has a brilliant cultural heritage with distinct and well developed language and art forms. Santhals have also been politically active from pre-independence era and even now Jharkhand has a Santhal chief minister. However, though it is progressive tribe, not all people have similar opportunities. Poverty is rampant and development is patchy. Smaller groups like Mal-Paharias within larger Santhal territories are still behind the local mainstream groups. Many of the challenges toward economic stability and an empowered society remain. This area has poor literacy (38% overall), livelihood depends on agriculture and educational opportunities beyond school are limited. Migration is common and among social issues, alcohol use is rampant. Mining industry and poor overall development due to long-term neglect has led to local insurgency, which is another challenge for the region and community work.

This project started as a Primary Health Care project with initial emphasis on improving health access and women's empowerment through self- help strategy. During the life of the project Jharkhand became a separate state, National Rural Health Mission (NRHM) started and much emphasis was given to development initiatives through women's self-help groups. MCH as the project implementer has also seen many changes over this time. The context for the third phase of CBPHCP is different with more actively functioning public health system which is held accountable by the district administration. Now SHGs are given due recognition as important functionaries for implementing economic development activities by government agencies and there is better overall infra-structure and implementation of local self-government system (PRI).

1.5 PROJECT DESCRIPTION

1.5.1 Overall vision of the Project

Vision: Sustainable, Healthy and empowered backward communities, transformed by congregations in a process that is enabled by the Mohulpahari Christian Hospital.

The vision indicates the overall commitment of MCH towards the local community and the Church. Being holistic in nature, it needed special effort and new way of working with the community. This is a challenge for a service oriented organization.

1.5.2 Project Program Objectives

a) *Awareness and capacity building.*
- Awareness of life condition in target groups.
- Target groups organized in functional groups.
- Training and capacity building of staff related to the project.

The project works with women as the main target group. They were organized in Self Help Groups and educated, encouraged and supported to address economic and social needs. Most groups were linked to nationalized banks for accessing loans for economic activities. In the early phase, strong groups took on contracts for development related intervention in rural area through Block Development Office.

Life skills, livelihood and career related training for youth has been part of the input. Mal-Paharia villages were identified as special needs communities and small programs to provide additional educational input was added in the second phase. Congregations, leaders from 14 congregations, local committee members and PRI members were also targeted for capacity building training programs.

b) *Sustainable livelihood.*
- Sustainable agricultural practices.
- Sustainable management of natural resources.
- Income generating schemes.
- Saving and credit.
- Energy saving schemes.

Activities were implemented by Rural Development Dumka during the current phase. Main inputs consisted of bio-based farm input to improve yield, tree planting, home based IGP and promotion of smokeless stove. Type of trees distributed was fruit and timber trees. Some of the IGP trainings provided to SHGs were candle, soap and pickle making. The project staff worked on the savings and credit schemes for SHGs with training and support for grading for bank loans. Inputs were based on request by the groups or identified by the staff. Demonstrations were done by RD staff in the community and farmers/ families adopting the bio-based farm inputs were noted.

c) *Health and hygiene.*
- Mother and child care.
- STIs and HIV/AIDs awareness.
- To improve water and sanitation situation in India.

Emphasis on health input significantly reduced in this phase primarily due to improvement in public health system. Preventive and primary care services have improved overall in project area. CHVs have continued to provide family level health education and support women in accessing care. Referrals for serious illnesses, delivery and surgeries have increased with additional benefit from government insurance scheme (RSBY). Periodic mobile health camps have continued to villages providing screening for diseases, care and referral. HIV/AIDS related education through film screening in the villages is going on by 4 animators who organize and execute the screening and related discussion periodically.
Training on STI and HIV/AIDS related stigma and discrimination for MCH staff and nursing students and awareness programs on HIV/AIDS for youth was organized as part of this objective. In the earlier phases, Santhali language radio program on health issues especially HIV/AIDS were prepared by MCH staff and recorded and broadcasted by NELC recording studio.

d) Human rights and advocacy

a. Retaining traditions and customs of tribals.

Right education started in current phase with the help of a socially active lawyer who has conducted many training sessions and given detailed information on rights related to general and tribal issues, PRI and role of citizens in PRI. Village leaders including PRI members have been included in training on the role of PRI**.** Community members have been supported by staff to file RTI (right to information) petitions.

1.5.3 Quantitative and qualitative changes expected as a result of project intervention (activities) are listed in the project document as follows-

Objectives quantified:

- No. of SHGs, youth groups and Gram sabhas formed and strengthened
- No. of children made literate
- No. of alliances of SHGs / CBOs formed and strengthened
- No. of awareness trainings related to migration, hunger and social security, identity crisis, resource management and legal aid programs organized
- No of skill development trainings on leadership, accounting, administration, PME, PRA, IGP, agriculture programs organized
- No. of HIV / AIDS awareness programs organized
- No. of HIV /AIDS Santhali Radio programs broadcasted
- No. of community organizations / groups become registered members of shake holders committee
- No. of health / environment regeneration programs conducted and peoples participated
- No. of training organized for youths on career guidance, income generation activities and social security
- No. of workshops organized for indigenous and tribal people on tribal self-governance system
- No. of women leaders trained

- No. of staff members trained
- No. of Grain bank promoted for people's benefit
- No. of water harvesting structures constructed
- No. of patients referred to MCH from community
- No. of undernourished pregnant and lactating mothers provided care and support
- No. of homes and schools and clinics with hand washing facilities near the toilets
- No. of people using the hand washing facilities

Qualitative description of change

- By the end of the project period 60% community would have the capacity to reduce the risk and vulnerability to STI/HIV/AIDS
- By the end of the period people's organization would have developed knowledge and capacity of leadership, livelihood and collective actions against violation of their rights.
- By the end of the project period the SHGs CBOs and stakeholders would have increased level of advocacy against land alienation, forest degradation, migration, violence against women and adolescent girls
- By the end of the project period 80% of the communities would be engaged in environment regeneration, conservation and protection activities.
- By the end of the project period 80% of the tribals would have enhanced knowledge of CNT and SPT Act and capacity to take collective actions against violation of these rights.
- By the end of the project period 90% women, men and children would be made aware of consequences of poor water and sanitation condition.

The detailed project document includes an item-wise numbers of activities to be done over project period. A target was set with number of programs to be conducted for each year, which was the main guiding document for project implementation. Descriptive report and target achieved is submitted to funding partners yearly.

2. MID TERM EVALUATION OF THE CBPHCP PHASE III (2011-2015)

Normisjon commissioned a mid-term evaluation of the phase III of CBPHCP in early 2013. Due to unavoidable reasons it was postponed and was carried out in September 2013.

2.1 Purpose of Mid-Term Evaluation

The purpose of mid-term evaluation of CBPHCP is to assess the progress of the project and analyze reasons for gaps if any and assess long-term sustainability of the project.

2.2 Focus

1. Follow up of the evaluation recommendations from Phase II, 2004-2009.
2. Evaluate progress of Phase III at Mohulpahari Christian Hospital in Congregation Based Primary Health Care Program, and in particular assess if the project's organization, management, operational and administrative procedures are adequate in relation to the achievement of the stated project objectives.

The specific areas identified were

i. Organizational design and its effectiveness
ii. Efficiency of administrative structure and processes
iii. Relevance, efficiency and impact of project activities towards realizing the objectives and vision of the project

2.3 THE EVALUATION TEAM

The team consisted of the following persons-
Dr. ShantidaniMinz, Professor of Community Health, Christian Medical College, Vellore
Mr. Antony Samy, Independent consultant- Community Transformation
Mrs. Maria Kisku, Principal School of Nursing, Mohulpahari Christian Hospital
Dr. Isaac Jebraj, Retired Professor of Orthopedics & Independent Consultant

2.4 THE METHODS OF EVALUATION:

i. Review of documents- The external team members reviewed the following documents-
   - Annual plans
   - Annual narrative reports
   - Budget
   - Minutes and important correspondence
   - Annual accounts and audit reports
   - Monthly health information reports by Community Health Volunteers (CHV)
   - Registers maintained by staff
   - Sample of training reports and training material
   - Books and accounts maintained at MCH
   - Evaluation reports of MCHDP, CBPHCP phase II
   - Project document 2011-15

ii. Site visits- The team visited the and interacted with the following groups between 20th and 27th September 2013-
    - Two Congregations
    - Members of 6 SHGs and some families in villages,
    - CHVs, animators, congregation leaders, evangelist and pastors in villages and at the workshop on 24nd September – workshop involved visioning exercise, needs assessment and problem tree using participatory methods (list of participants and learning in annexure 3)
    - Mukhiya and counselors in the villages
    - Dr. Manjula Tudu – Project coordinator
    - Dr. Pradip Soren- Deputy Medical Superintendent
    - Dr. Joyen Kisku- Medical Superintendent
    - All project staff – field staff were interviewed individually and as a group. Accountant met separately
    - Discussion with Mrs. Maria Tudu -Principal School of Nursing and member and project management committee
    - NELC partners – Leaders of RD and Radio program (Mr. Enos and Rev. Lucia) and team at Dumka
    - Central coordinator Mr. Christopher
    - NELC Synod leaders- Moderator Soren, Mr. S. Jha (Secretary), Mr. M. Hansdak' (Treasurer) at Dumka
    - Other groups visited and met at Dumka and villages: Pradan (NGO), AIDP central and field staff, ICDS staff, PHC medical officer, Lok Man (NGO)

iii. For study of financial system interviews were done with-
    - Administrators of MCH- Dr. J. Kisku and P. Soren
    - Administrative staff
    - Accountant (currently CBPHCP)
    - Visit to hospital departments and stores

iv. Reflections and discussions by the evaluation team and informal interaction with MCH staff

v. Debriefing

vi. Drafting, circulation and finalization of evaluation report.

3. THE EVALUATION FINDINGS

The evaluation findings are presented in the following sections

3.1 Organizational Structure, Partnerships and Collaborations
3.2 Administrative Structures and Processes
3.3 Project activities

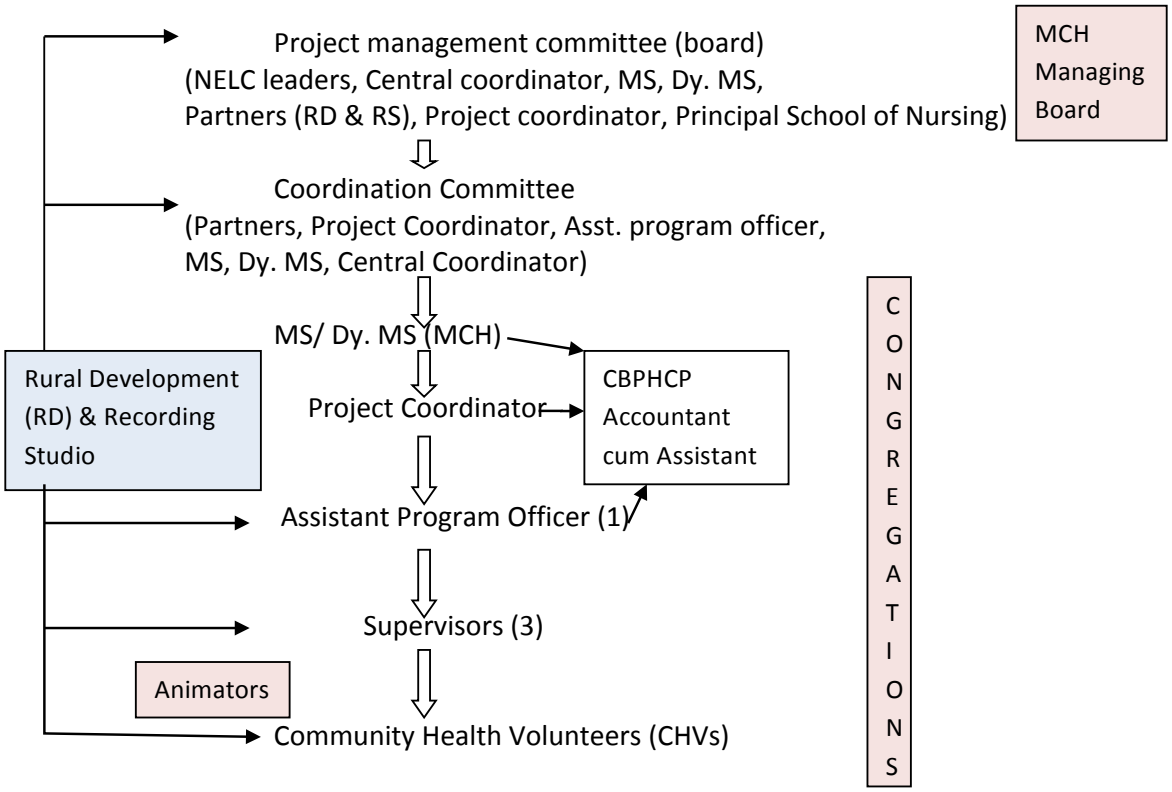
Each section has sub-sections with specific recommendations.

3.1 ORGANIZATIONAL STRUCTURE, PARTNERSHIPS AND COLLABORATIONS

3.1.1 ORGANIZATIONAL STRUCTURE

3.1.1.1 Observations-

i. The currently functioning organizational structure of CBPHCP from minutes and discussions is presented below:
(Compare with organogram in annexure 1 as proposed in the project document)



ii. ***The role of MCH managing board as a separate entity is not clear as many MCH leaders are also directly involved in CBPHCP. Animators work in a group independently of all other activities, directly at the community level. Congregations interact with the project workers but the committee at the congregation level is not actively involved in planning and monitoring of project activities. RD is a partner in implementation therefore forming part of the organizational structure at the field level too. However, there is lack of clarity in line of command and control at operational level.***

iii. ***Project coordinator and staff individually and collectively are limited to managing the project activities. Project coordinator needs to be directly responsible and accountable for all administrative processes, personnel management and project implementation under the overall supervision of the CEO of MCH and within MCH policies.***

3.1.1.2 Strengths-

i. The strategy to engage congregations as the vehicle to bring healing to the larger community is still the biggest strength of CBPHCP.

ii. As envisaged in the project proposal, the apex committee is to play an advisory and guiding role while also playing an overall monitoring role. This is important since the project holder is NELC and NELC with MCH are named implementing partners. This group meets once in a quarter.

iii. The coordination committee meets every month and reviews the reports and plans. Information from RD partner is shared.

iv. Supervisors are responsible for a specific cluster; interacting with a group of villages, CHVs, SHGs and congregations. They are responsible for all activities in the cluster.

v. Rural Development of NELC supports CBPHCP in specific input in IGP training and innovative agriculture techniques.

vi. MCH provides administrative support to CBPHCP (MS & Dy. MS).

vii. Forum for sharing of best practices present in the coordination committee.

viii. Structure is apt for multilevel monitoring- SHGs and congregations at community level, coordination committee at project level, MCH at institutional level and project management committee at NELC level.

3.1.1.3 Constraints-

i. There is lack of clarity of roles and responsibilities of different committees resulting in inadequate monitoring. Members representing NELC do not play executive role. Apart from their official role, the expectation is that each will bring in personal expertise. Input from committee members in the matters related to process of project implementation, administrative processes, financial management is inadequate. The head of the project is responsible to look at all project matters. This has not happened in some areas.

ii. There is issue of accountability at the leadership level.

iii. Line of control is not clear at operational level

iv. Congregations and SHGs are still at a beneficiary status.

v. External experts are not part of the apex committee as planned.

vi. There is no "team" of functionaries at the cluster level therefore; cluster is not a functional unit.

3.1.1.4 Recommendations-

NELC

i. As NELC is the primary stakeholder of the project for legal purposes, it should appoint a point person with adequate power to monitor fund management and project implementation.
ii. Empower central coordinator with power, access and funds to scrutinize, monitor and guide all NELC projects.

Project Management committee

iii. Project management committee meetings should ensure effective implementation and monitor the smooth operation of CBPHCP within the framework. They should meet once in a quarter reviewing project progresses, identifying gaps and recommending remedial measures.
iv. Project coordinator should be accountable to project management committee.

Coordination committee and partners

v. Partners should be accountable to Project coordinator for program as well as budget.
vi. It is advisable to modify the composition of coordination committee to include the three partners, central coordinator, program officer and two nominated members from congregations (one pastor/ evangelist and a woman leader). This will bring ownership, feedback from the community and guide the implementing team in better need based interventions. This will also ensure accountability and transparency.
vii. Project coordinator should be the lead person in this committee. Role of MCH CEO and NELC leadership is not useful here since this committee should look at operational

aspect of the project. Frequency of meeting for this committee maybe once in two months, but more frequent if needed.

Project

viii. Project staff should meet monthly to review and plan. They should report to the coordinator about progress of all activities including RD inputs.

ix. Cluster level team building including representation from congregation is needed. Decentralization to cluster with an office for the Field staff (Supervisor) if possible. This will help in promotion of field based activities.

Partner Congregations and Church

x. Bring congregational leaders at center stage as equal partners and involve them in planning and implementation.

xi. Share the vision of the project in church and ensure active involvement. Pastors can plan Bible studies on related topics to generate interest, and understanding of alignment of the project goal with Christian values.

3.1.2 COOPERATION BETWEEN PARTNERS – MCH, RD AND RECORDING STUDIO

3.1.2.1 Observations-

i. CBPHCP has brought together a unique partnership between three NELC organization with very rich history and successes in a challenging context. Each brings different expertise and strengths.

ii. CBPHCP has been working with Recording studio since the phase I and has contributed towards development of health based programs being aired as part of Santhali language program. As noted in the phase II final evaluation, the programs are of good quality and have value. Listenership for this program is more in Assam and less in project area. Thus direct contribution to the project population is limited. Adequate number of scripts have been developed by MCH doctors and recorded programs by doctors, nurses and nursing students are available now. The studio feels confident to continue the programs with only expert input from medical professionals reducing the burden on them. It is important to note that the Mal-Paharia groups are the fruit of Radio-ministry. Therefore more cooperation with the follow-up workers (Radio- ministry) can provide additional support for community organization work of CBPHCP especially for remote villages and Mal-Paharia groups.

iii. RD group brought in a new dimension to the work of CBPHCP moving it from primarily health orientation to more development orientation. Rich experience in accessing government programs, well developed monitoring tools and experience of work with SHGs are all beneficial to CBPHCP. However, the role of RD was limited largely to provide consultancy like services. RD provided trainers when asked by CBPHCP, trained SHGs on IGP when the specific demand came and demonstration for agricultural techniques and tree planting were provided as a contract service to CBPHCP. RD has not

invested itself in overall planning of development inputs and follow up processes for adaptation of new methods, or marketing of products from IGP. In addition to the community and beneficiaries, the less experienced field staffs of CBPHCP would benefit from handholding by RD staff. True partnership with supportive relationship and openness to change will benefit the project immensely.

iv. MCH & CBPHCP- Bringing the best from the partners is the responsibility of the lead team and leaders of the project. This needs openness and break in existing structures and hierarchy. NELC organizations are used to working independently and no example of partnership exists at present. This standard practice has limited the possibilities of the value addition to CBPHCP through a real partnership with recording studio and RD.

3.1.2.2 Constraints-

i. Fixed structures within which each partner functions
ii. Full potential of each partner is not brought together
iii. Lack of clarity in roles and responsibilities leading to more of consultant role played by RD and limited participation of recording studio in activities other than radio programs

3.1.2.3 Recommendations-

i. All partners must have written agreement to ensure their commitment to bring about impact through all the interventions/activities with measurable outcome indicators
ii. Coordination and interaction level should be of higher level to reach overall goals of the projects.

3.1.3 ENGAGEMENT WITH GOVERNMENT AND NGOS

3.1.3.1 Observations-

i. The proposal envisaged collaboration with NGOs e.g. ESAF for marketing of products and work with Block Development agencies of the government for supporting SHGs. During the current phase NGO collaboration has been limited. Few NGOs are involved in agriculture related programs and Agriculture Integrated Development Project (AIDP) of NELC is also involved in similar activities in part of the CBPHCP area. There is no cooperation with these agencies, primarily because the project inputs have been limited to providing training under each objective. NGOs like PRADAN and Catholic agencies are good resource and support for development activities. However, the project is unable to develop meaningful relationship with them.

ii. CBPHCP staff support government health activities by participating in mass programs like Pulse Polio. They also support the activities on the ANM for preventive care by awareness building. CHVs interact with women, families and SHGs to increase awareness on health issues and health programs. MCH doctors are participating in Government health camps. CBPHCP does not have direct or formal link with PHC level programs.

iii. Functional and active SHGs are getting linked to the block level program with the help of LEO (Lady Extension Officer). This is not done by the project in an organized manner. Project is also working with SHGs started by other NGOs or Block functionaries to provide agricultural input. More formal and definitive link between project and block level functionaries is needed for future as this whole initiative is getting institutionalized by Jharkhand government.

3.1.3.2 Constraints-

i. Project staff is not able to maintain relationships with government offices and NGO due to the style of current program implementation that engages many of them for centralized trainings. They are not able to give enough time needed for high level of constant engagement.
ii. Lack of formal training and experience is a constraint for many project staff in being proactive with other organization.
iii. Santhal people are by nature soft spoken and humble in presenting themselves. This was observed to be a hindering factor for all project staff and the coordinator in communicating with other professional and social action groups.

3.1.3.3 Recommendations-

i. Develop formal/ operational link with Block development office, especially LEO for inclusion of SHGs under federation at Panchayat level.
ii. Project coordinator and staff should participate in PHC review meetings and gram sabha meeting (PRI).
iii. Project coordinator or another doctor from MCH should regularly participate in district level health department's review meeting. In this forum they will be able to contribute to ground level realities, special needs of remote groups like Mal-Paharias and help identify gaps in services.
iv. Project staff and other MCH staff linked to CBPHCP should undergo exposure to other similar programs to learn about and develop skills in networking and communication.

3.2 ADMINISTRATIVE STRUCTURE AND PROCESSES:

3.2.1 PROJECT MANAGEMENT

3.2.1.1 Observations-

Project management of CBPHCP is directly under MCH. This brings strengths as well as challenges to the project implementation. Main issues are summarized in a table-

	Strength/ benefit	Challenges/ Constraints
Overall management	1. Overseen by MS and Dy. MS of MCH, bringing in experience and insight. 2. Support from MCH support staff given if needed. 3. Funds advanced when transfers are delayed. 4. CBPHCP programs are owned by MCH and they participate and contribute to it as extension of their role.	1. CBPHCP management system is not made independently accountable. 2. Up to date systems for project processes are not developed as MCH is still using older systems- e.g. paper/ book based accounting, documentation, reports, access to Internet etc. 3. There is minimal decision making for program implementation and all activities are carried out as a routine as written in the project document. For administrative issues the decision making process is centralized at MCH and not at the project level with little participation from other players in the team. 4. The team function is not oriented towards the goal and there is lack of opportunity for introspection. The value of monthly meetings (coordination committee) is limited. Field team does not have a monthly review as planned in the proposal.
	Strength/ benefit	**Challenges/ Constraints**
Human resource	1. 5 full time staffs are employed by MCH. This brings in a sense of belonging. Few are provided housing benefit by MCH additionally. 2. 4 field staff are managing and huge operation 3. Doctors and nurses are	1. Current full time staffs do not have the competency to manage the project. None of them have undergone specific training for developing competency this project demands (Specific recommendation in 2009 evaluation) 2. The current coordinator is not fully involved and lacks competency in managing a community project with development components. There is conflict in the role she is expected to play with high

	trainers for the project. 4. Driver for the project vehicle is deputed from MCH. 5. CHVs have played important role in the past and most still do.	demand from hospital while overseeing a project that also requires high input. 3. CBPHCP has not benefitted by the competency of the partners (RD- project management, recording studio- HR, documentation and public relations. 4. One woman field staff needs male co-worker's support for community visits. ANM is also woman and both are not yet expected to work independently. 5. Animators are redundant as IEC activity is high from public sector now. They do not contribute to development work as planned. 6. Able CHVs should become trainers or field assistants.
Operating routines	1. All project staffs come under the purview of MCH staff service rules. 2. Purchases, programs are done as per MCH norms.	<u>Important area for consideration-</u> 1. Following MCH staff rule binds the field staff to hospital work timing. Day to day reporting & planning is also done in the same manner taking away valuable time for supervisory staff. 2. Personnel work planning is not done in project mode (e.g. advance tour program). 3. Organized trainings take up most of staff time. As they are mostly organized in MCH campus, taking staffs away from field. 4. Remotely located villages receive very little input from project staff.
	Strength/ benefit	**Challenges/ Constraints**
(Continued from previous page)		5. CHVs play a pivotal role. All project activities stop if CHV is not functional or leaves. 6. There is a Centralized decision making at MCH level, leading to limited delegation to project staff. This may be due to lack of competency. . 7. project.

Financial Management	1. Under the umbrella of MCH. Overseen by MS and Dy. MS. 2. Audit is done separately for project.	1. Financial system in MCH is outdated. 2. A new project accountant without experience is filling in for MCH. He is not available for CBPHCP fulltime. 3. Vouchers lack narration and hence not a valid document. Plain paper estimates are submitted as bills, which is not acceptable. 4. Lack of clarity in financial transactions- Many transfers between CBPHCP and MCH accounts are done through memos/ vouchers/ cheques. Salary transfers should be made through a standard system of accounts transfers. 5. Accounts for project should be managed by accountant directly with the following flow: Expenditure (according to budget head) ↓ Accountant (ensuring all receipts/ vouchers are authentic) ↓ Approval by project coordinator ↓ Submitted regularly to MCH(MS/ Dy. MS) ↓ Quarterly financial statements prepared by accountant.
	Strength/ benefit	**Challenges/ Constraints**
		6. Lack of a system of Petty Cash makes it difficult to manage day to day project work. Fund management without separate cash book for project is needed and central office in charge of external funds has not developed an appropriate system for MCH run projects. 7. Financial statements should be prepared by the accountant and internal audit done every 3 or 6 months to ensure that systems are in place.

3.2.1.2 Recommendations-

Overall management

i. Empower coordinator to run the project including fund management and provide support from MCH and Central office
ii. Ensure commitment by committee members to assist the project team in identifying gaps, giving direction and ensuring correction.
iii. Develop Project operation manual, staff service rules, financial policies and job description of every stakeholder.

Human Resource

i. Do away with CHVs working for more than 5 years who are not performing.
ii. Incentive based payment for CHVs. Add incentives for better performing supervisors.
iii. Upgrade efficient CHVs to field assistants and trainers, part or full time.

Operating Routines

iv. Separate guidelines and job descriptions for project staff must be prepared by MCH.
v. Minimize training at hospital. Move to the community, open field office in clusters if possible

Financial Management

vi. Audit objections or remarks should be followed up by the central office CEO for correction and ratification.
vii. Appropriate and transparent financial policy and accounting system needs to be in place with immediate effect. Computer based accounting program is highly recommended.
viii. NELC should make available for all programs and projects, an accountant/ finance manager at central level who would be accountable for fund transfers, receiving financial statements from projects and periodic monitoring of each project. This is needed to bring uniformity in funds management and for use of best practices.

3.2.2 MONITORING AND EVALUATION (M&E) SYSTEM OF CBPHCP

3.2.2.1 Observations-

The understanding of M&E is lacking in the team. There is no one trained in this aspect of project management and training by RD did not play a role in improving it.

Opportunities through existing system are-

i. Health related information collected by CHV- Though reports come from approximately 35,000 population, it can be used to look at trends and lacunae in specific services e.g. immunization, identify issues for awareness building and use for planning specific input. The data should be used for monitoring the objective related to health care access.
ii. Large number of training and demonstration are held. Planned input-output-outcome link with reporting format developed for each activity and indicator will help in monitoring the progress.
iii. Congregations and SHGs can add value to M&E by good quality community monitoring of the project. This can be a regular simple feedback session where verbal feedback is documented. This forum can also be used for problem solving, planning, setting priorities/directions and coming together as a praying community. However, this calls for flexibility in programs and sharing of power by the managers; a new way of working with the communities for the team.
iv. Coordination committee should function as a higher level monitoring team with open communication regarding project progress and critique by members. Central coordinator (and a centrally based finance manager) can provide overall monitoring for components by 3 partners, specific professional input in project management and good management practices by all partners.
v. Project management committee (Board at central level) should participate actively in monitoring overall progress and fund use. This is needed since the fund flow is through NELC trust and final financial accountability lies with this trust.

3.2.2.2 Constraints-

i. Project implementation is activity based without considering outcome related indicators. This has led to poor M&E system.
ii. Lack of competency of the project staff and project leaders in project management with substantial development component

3.2.2.3 Recommendations-

i. Consider participatory M&E involving SHGs and Congregations
ii. Re design the project objectives aligned with outcomes and appropriate indicators.
iii. Develop impact and outcome indicators with community participation and monitor closely.
iv. Develop process plan for each objective ensuring community and congregational participation at all level.
v. Develop procedures and protocol for every interventions

3.2.3 COORDINATION COMMITTEE AND PARTNERSHIPS

3.2.3.1 Observations-

i. The same individuals are members of the coordination committee and project management committee resulting in unclear roles and lack of accountability. As evident by minutes of committee meetings, the project management committee and coordination committee are playing similar roles with limited input towards effective and constructive project implementation.

i. Administrative issues among partners are handled according to the norms of the institutions involved. Financial transactions are formalized now and are managed smoothly. There is smooth functioning between partners.
ii. Currently RD and Recording studio are not actively bringing in their expertise to guide, support and monitor the project. In addition there is inadequate involvement and accountability for RD initiated inputs that require specific expertise. RD involvement is at the level of a consultant.
iii. Radio programs have been dependent on doctors for script and MCH staff for recording the skit. This relationship is also not a partnership at present. However, there is readiness for change.

3.2.3.2 Constraints-

i. Few staff of MCH are members of all committees and they are also involved directly in implementation of CBPHCP. These members are not able to play supervisory role as project management committee.
ii. Coordination committee meetings have been limited to reports and plans by project staff and not utilized for bringing the strengths of partners together to support the project.

3.2.3.3 Recommendation-

i. Radio program team need to take over responsibility for developing the script and voicing for the concepts given by the doctors as their time is valuable for patient care.
ii. Follow-up workers for Radio program should work closely with project staff for mutual benefit.(*Other recommendations in previous section*).
iii. RD must be involved as an equal partner to see the project inputs through to its outcomes and impact.

3.3 PROJECT ACTIVITIES:

Project objectives address four distinct areas for intervention-

3.3.1 Capacity building of women and youth identified as the target population through organization of SHGs, life skills and leadership training. Linkage to government schemes for economic and community development work for SHGs is one of the strategies. Training of youth is focused towards health awareness and prevention of communicable diseases such as HIV/ AIDS.

3.3.2 Sustainable livelihood using innovative agricultural techniques, income generation program and energy saving interventions. Interventions for this objective were designed based on RD experience and expertise.

3.3.3 Health and hygiene – this addresses access to preventive and curative care through awareness building, referral services and link to public health system. Sanitary practices to improve health are new components in phase III of CBPHCP.

3.3.4 Rights and advocacy- this is a difficult area to get involved for a Hospital in rural setting with limited links to political power. Persons in faith-based organizations like MCH are also not well versed with human rights laws. In addition, advocacy is out of comfort zone for most service-oriented organization. It takes courage for an organization like MCH that has to make an effort to remain financially viable, to start work in controversial area of advocacy.

3.3.1 CAPACITY BUILDING OF SPECIFIC TARGET GROUPS

3.3.1.1 Observations-

i. Women who became SHG members were the main target group. The groups started by the CBPHCP in the phase I & II have received continuous support by project staff and training to run SHGs, link with banks, accessing government scheme for income generation for members and development input for the community. Multiple trainings on leadership, specific skills related to SHG management and skills for income generation were conducted for the women. Though it is difficult to verify the content, assess quality and volume dispensed, successes are visible in the form of women leaders, SHGs utilizing government schemes and improvement in income of families of these women.

ii. CHVs have played a pivotal role in work with SHGs and most successful SHGs are characterized by a progressive leader and an active CHV. In the early days of SHGs the women depended on CHVs and project staff for support but subsequently some of them have garnered support from their families and community members and have moved on. They now have the confidence to do it by themselves. Though few, these women groups with empowered women are the successes of CBPHCP.

iii. Capacity building of CHVs in providing information, supporting SHGs and guiding them was important input by CBPHCP.

iv. Youth have had limited input in life skills, livelihood and leadership. The value of the training was not possible to assess as no participant could be interviewed. This

highlighted the limitation in the process of identification and training of participants, which was done by only the CHVs.

v. Capacity building of congregation leaders, committee and members of the worshiping community has lacked planning. E.g. PRA training for congregation members/ leaders was done without them playing a partner's role in project implementation. This has been repeated every year without considering the usefulness and expected outcome.

vi. CBPHCP Sunday was observed in different congregations in the earlier phase. The suggestion in last evaluation was to broaden this by celebrating one Sunday in NELC calendar as CBPHCP Sunday similar to the Healing Ministry Sunday observed throughout India. This was reportedly misunderstood and removed from current phase.

vii. PRI members and office bearers have received input from CBPHCP towards need for addressing community issues.

viii. Capacity Building of Staff-This activity of the project has been seriously neglected leading to lost opportunity for fulltime field staff on the project. In turn, the project has lost time when a better trained and competent staff could have contributed to it.

ix. Specific Intervention for Mal-Paharia communities-Three small Mal-Paharia communities are adopted by the project in the third phase as a special program. This is a special group as they are identified through the Radio Ministry. The main intervention is additional educational input to support children going to school and reduce dropout. This is challenging since the school system does not always have motivated teachers and the burden falls on the volunteer teacher. Other inputs in these communities are limited though they have less livelihood options, more poverty and ill health. CBPHCP relationship has given these communities acceptance in Santhal majority project. Some individuals among them are highly motivated witnessing to non-Christians. There is possibility for life-changing transformation for these families and though them the rest of the villagers by small but focused health and development input.

3.3.1.2 Constraints-

i. Project staff lacks up to date knowledge and skills in organizing trainings and fulfilling resource person's role for community needs.

ii. Large number of trainings was held in MCH premises or similar central locations during regular working hours limiting wider participation from the community .CHVs were asked to identify participants for most of the centrally organized trainings. Dissemination of information for programs was not done in planned manner.

iv. Much training was conducted to reach the targets set in an activity-based plan. This was due to the lack of specific outcome indicators to measure capacity building efforts.

v. *Many SHGs have progressed and gone far ahead of the project staff's competency. Therefore project staffs are not actively engaged in meeting their training needs*.

3.3.1.3 Recommendations-

Project Staff and Coordinator

i. All staff should go for TOT and also identify few CHVs to become trainers. Except for few topics like legal matters other topics should be handled by staff.
ii. All the staffs need to undergo facilitation training and community organization training.
iii. A strong and appropriately equipped leader is needed for the team. Either a full time coordinator be appointed at the earliest or the person should be seconded from MCH with definite allocation of time and after appropriate training.

Training programs on capacity building

iv. Most of the training should be conducted at field level and at congregation.
v. IEC materials like flip charts, posters, DVDs, books, periodicals, magazines on different subjects should be obtained. Other training tools can be developed locally or adapted which are culturally appropriate on line with SARAR tools in Santhali. Region songs can be powerful tool to spread the message. School health modules available with Water Aid India can be followed.
vi. All existing training should be scrutinized by the team for need and appropriateness. E.g. very basic PRA training. Modules and training plans should be filed.
vii. Develop need based training and develop specific modules. All trainings should be part of the process so the end result is a specific change.

Self Help Groups

viii. The SHG movement is undergoing consolidation now and much effort is needed to ensure that groups started through CBPHCP are part of the mainstream SHG movement supported by government's development work and formation of a federation at Panchayat level. CHVs and cluster-in-charge should meet the groups and give hand holding support as per the need.
ix. All functioning SHGs should be linked to LEO and provided support for at least 2nd Grading.

Congregations

x. Project document need to be shared with the congregation leaders and they should get involved in all aspects of the project starting from planning, implementation and monitoring. Their authority and obligations should be clearly communicated to them.
xi. Congregation should be communicated when the project team is facing problem and seek the prayer support

Mal-Paharia group

xii. Develop integrated micro-plan for each Mal-Paharia hamlet with interventions covering farming, health, water and sanitation, other livelihood options, savings and supplementary income. Identify more such hamlets in target are but these requires high resource based input.
xiii. The volunteer teacher can be made as CHV and project activities should be extended

xiv. School of Nursing should consider a community-based program for ANM and GNM students to learn about the needs of marginalized poor.

xv. Teachers need to be trained. They can visit Compassion project of NELC to get some exposure and learning on child dynamics. Modules from this project can be taken to teach. The need for extra input should be reviewed regularly since the govt. schools with para-teacher is functioning in some villages.

Other groups

xvi. More MCH staffs who directly and indirectly contribute to CBPHCP and staffs of partners should also benefit from allocation of funds for staff capacity development.

xvii. Financial input towards capacity building should be viewed as a long-term investment for local community and NELC and planned accordingly. Specific input for career counseling for youth, coaching classes, vocational training linkage and scholarship etc. are needed for project area youth. It strongly advised that members of NELC be identified and trained in specific skill based under-graduate/post-graduate program e.g. management, accountancy, public health, nursing, rural development, agriculture etc.

3.3.2 ACTIVITIES TO PROMOTE SUSTAINABLE LIVELIHOOD

3.3.2.1 Observations-

i. Rural Development group of NELC brought expertise to support CBPHCP in this new dimension related to health. Economic development and sustainable environment and livelihood bring in a paradigm alien to health professionals but essential to "holistic health" or "fullness of life" concept.

ii. The strategy was to train and conduct demonstrations for community members both men and women in improving agricultural yield by non-chemical methods and green crops, provide tree saplings for improving green cover, interest base IGP and promoting use of smokeless stove to reduce wood fuel use. These made 10 line items in the plan.

iii. Main beneficiaries are SHG member and their families. Many have tried out the bio-based farm inputs once but few have continued the practice. Most could not estimate the benefit, as the method for documentation was not part of the training. There was no reinforcement or handholding after initial input and no one followed up for promotion and adaptation of the methods. This lead to communities losing interest in the interventions.

iv. Some of the methods for preparation of special fertilizer and charcoal are not easily adaptable by individuals. Technology transfer to community members and skill transfer for training and monitoring to CBPHCP staffs were not planned leading to dependence on RD team.

v. Despite the bio-base farm inputs being economically sound and ensuring improved and sustainable crop yield, RD is not worked towards a business plan. RD team is busy and seemed preoccupied with other result oriented; time bound funded programs and is

unable to work towards the goal as a partner taking responsibility for success of the project.

vi. Lack of visible impact of RD interventions was attributed to poor community organization by RD team. There was poor participation of farmers/ villagers not linked to SHGs. Community level programs are dependent on the ability and influence of CHV. This is seen as a result of limited involvement and lack of accountability on the part of field staff. This also highlights limited involvement of congregations in the project where they are not functioning as partners but only as beneficiaries.

vii. Skills like candle making, soap making are taught in isolation without plan for production and marketing. Groups that have succeeded in generating additional income have found or developed their own marketing support. Food preservation and pickle making is only used as very small scale seasonal activity bringing small amount of money.

viii. Savings and credit schemes for SHGs are not monitored and promoted actively by staff. According to the information available only 28 groups out of 153 (18%) have achieved grading for credit. Total loan availed by the groups last year is not available.

ix. Energy saving inputs was sporadic and some could not be continued due to lack of specific material.

3.3.2.2 Constraints-

i. Many ideas for household based activities for income generation have come from previous experience of RD and individuals in the community. These were not carefully analyzed to ensure adequate training input and support needed from project for marketing and sustaining the activity.

ii. Project did not have budget for supporting small income generating activities for small groups. SHGs have to depend on bank loans.

iii. Neither project staffs nor RD personnel took clear responsibility for planned follow up activity after a training or introduction of a new agriculture method.

iv. Technology transfer was not planned leading to only few beneficiaries.

3.3.2.3 Recommendations-

i. RD team should depute one person full time to oversee the progress of the objectives related to agricultural input, support and guidance to SHGs and natural resources management interventions. If not, one of the supervisors should be trained in this component and made responsible to manage the component.

ii. Project should seriously consider collaborating with AIDP. Visibility of the impact seems to be more as the interventions are need based and community oriented. They have lots of lessons on input strategy and operational strategy etc. AIDP's nurseries in project area at least can supply plants and vegetable saplings. Take their expertise in designing land development and agricultural interventions. Take their help in internal monitoring and review at field levels.

iii. Meaningful and continuous collaboration with other NGOs e.g. Lok Man, PRADAN, Catholic services, Sharda is needed.

iv. Instead of family based tree planting, community plantation at a larger scale should be considered in community and waste land with support from social forestry.

Organizations like PRADAN should to be consulted in planning. Roles and privileges of tribals under Forest Protection Act need to be studied and community should take advantage of the provisions. Few SHGs can start nursery to produce plants for selling at affordable costs.

v. NELCs project holders; Rural Development society and AIDP are operating in the same project villages. Most of their components can be linked and focused in these villages to maximize impact. Example-RD is doing water shed works for government, AIDP has farm based intervention and water harvesting structures, sustainable agricultural component is being implemented by RD through CBPHCP. These can be combined.

3.3.3 MATERNAL AND CHILD HEALTH, STI/HIV/AIDS EDUCATION, WATER AND SANITATION-

3.3.3.1 Observations:

i. Accessibility:
    a. CHVs are unanimous that poor have better access to health services in MCH due to referral system. Most people in the community also report this. Preventive services are made available by public health system and reported uptake is high. Awareness developed by CBPHCP overtime could have contributed to this.
    b. MIS collected by CHVs is from approximately 35,000 populations. This shows an improvement in hospital delivery from 46% to 64% between 2010 and 2012.
ii. There is reduction in deaths due to malaria from 9% of all deaths reported in 2010 to 3% in 2012 while proportion of deaths due to Tuberculosis is not changed.
iii. Mobile camps in the community are appreciated, but reports are not available to assess impact of the camps. Screening for chronic diseases is also done and the medical team feels that this is still needed.
iv. Impact of health care by MCH is not quantifiable due to lack of data capture at MCH. Total number of patients provided subsidized care by CBPHCP was not available.
v. Many staffs in MCH are interested to contribute towards the success of the project.
vi. No specific water and sanitation program activity were observed in the community. Few borewells have been dug in the past due to effort of project supported community action.
vii. Radio programs are of good quality but the numbers of local listeners are low. Though pamphlets about the programs are widely distributed project area population is still not aware of it.
viii. Government of Jharkhand is actively implementing programs under NRHM. Preventive services for maternal and child health are well developed and being promoted along with well-equipped mobile clinics by NGOs. Financial incentive is given to use public health system. Better equipped health centers and personnel are in place as compared to the time when CBPHCP was initiated.

3.3.3.2 Constraints

i. ***Currently CBPHCP lacks competency in designing and implementing a need based health program at the community level that will complimentthe expanding government health programs.***
ii. ***Quantitative data is not available at the hospital or project to assess the role of MCH in improving health status of the local communities in the current phase***.

3.3.3.3 Recommendations-

For the current project without major changes:

i. Reduce collection of health information from the community to birth and death alone. This can be used for analysis of trends due to impact of health servicesand be used for planning.
ii. IEC programs in the community should be need based. Need and usefulness of stigma related training programs should be reassessed.
iii. If mobile camps are continued, they should be planned to address specific deficiency in the public health system.
iv. Special programs need to be planned for Mal-Paharia communities. ANM should have special visits to the remotely located communities to improve health awareness and provide basic services.
v. MCH should make an effort to improve the medical record system.
vi. MCH doctors and project coordinator should participate in district health review meeting to report issues from hospital and project area.

Modify project's specific objective to address felt need of the community

vii. Alcohol use/ abuse -
    a. MCH should consider a program with referral and counseling for persons with alcohol abuse along with CBPHCP.
    b. Congregation based programs to build awareness about evils of alcohol and character formation for young people will be of value.
    c. Plan and support action by SHGs
viii. Water and Sanitation - Ensuring safe drinking water availability in the community by ensuring adequate numbers of functioning hand pumps, promotion of sanitation with subsidized toilet construction are programs that can be accessed by villages through awareness building and rights based action.Simple educational interventions like hand washing for school children can be taken up.

3.3. 4. HUMAN RIGHTS AND ADVOCACY

3.3.4.1 Observations-

i. This is a new area for MCH and CBPHCP to be involved in and is especially challenging to develop.

ii. CBPHCP has identified a dynamic resource person who is dedicated to rights and advocacy and is engaged in many initiatives.
iii. Quality of training input is good as evident by handouts given.
iv. Community leaders have received inputs in PRI, and their roles and responsibilities.
v. There was no planned follow up after advocacy training to document application of knowledge gained by the participants. RTI applications were reportedly filed but response was not documented.
vi. Land issues are not perceived as a significant problem now by tribal population hence its inclusion in project activities needs review.

3.3.4.2 Constraints-

i. There is a lot of potential for change if CBPHCP is able to increase knowledge about rights among PRI members and the gram sabha. This will need thinking out of the box, using community's strengths, empowering and power sharing, and learning to leverage with other powers. Current team needs to learn how to do this.
ii. Apart from competency, advocacy work requires courage and patience from all involved in it. If not taken as a priority area, this is likely to be neglected since there are other programs needing staff time.

3.3.4.3 Recommendations-

Within current project structure

i. Specific programs to develop capacity of community leaders (PRI) in identifying community needs and obtaining funding for it.
ii. RTI filing, follow up and further action should be part of the intervention under this component.
iii. Project staff should develop capacity to identify issues such as corruption within PDS, noted during evaluation visit and address them with legal support.
iv. Project can initiate and support community monitoring of all government programs.

3.3.5 VISIBLE SOCIAL IMPACT OF THE CBPHCP INPUT OVER 3 PHASES

I. Some SHGs have developed to become truly remarkable examples of empowerment and emancipation. Few women have become PRI leaders and playing decisive role in the local self-government. Few SHGs (leaders) are developing and supporting new groups, making social and economic change, have eliminated menace of alcohol from their communities and have truly become agents of transformation. Some SHGs take on collective economic activity like farming, vegetable growing etc. on a regular basis. They will not be considered a success by official SHG standards in India since they have not availed loans, but they have truly imbibed the spirit of SHG.

II. Socially relevant economic activity like Fair Price Shop, pond digging, road construction contracts taken up by the SHGs have contributed greatly to the community by ensuring

access to these schemes for the community without corruption. However, some of these are themselves affected by corruption at higher level and this is an area identified during evaluation for Rights Action.

III. Some women who were CHVs and SHG members have left the project but taken on larger role in the community. Unfortunately, the project staffs have not maintained relationship with them. SHGs are also not followed up if a CHV leaves the project. This has affected relationships with communities and development activities in respective villages.

4. FOLLOW-UP OF PREVIOUS EVALUATIONS

4.1 Final evaluation of CBPHCP phase II 2009

The final evaluation of phase II of CBPHCP in 2009 included follow-up of MCHDP evaluation recommendation. The table below summarizes main recommendations from this evaluation, and how and to what extend it has been addressed by the phase III of CBPHCP.

Observations/ concerns/ recommendation in Phase II evaluation	How it is addressed in Phase III CBPHCP project document	Current status
Appropriate documentation, information system and use of information from project, hospital and finance related for review, planning and feedback. This was first noted in MCHDP mid-term evaluation in 2003 and considered an important factor for sustainability.	No specific plan	Modified documentation system for training programs requiring that most project staffs are engaged in each training program. No new system in project and hospital. Service related information is not generated for MCH.
Specific and focused effort to share vision of CBPHCP with congregations and community leaders using resource persons within NELC and with higher level involvement of NELC leaders.	Capacity building trainings planned for congregation and community leaders. CBPHCP Sunday celebration removed from plan.	Many programs for community leaders and congregation members held on PRA methods- this was not linked to a specific outcome. Rights training for PRI and SHGs have been useful. Shared vision for project is still lacking among the congregation leaders. Congregations are still not involved as partners

Observations/ concerns/ recommendation in Phase II evaluation	How it is addressed in Phase III CBPHCP project document	Current status
Develop referral –feedback system from community (CHV) to hospital and feedback though project.	Plan for better referral system	No change
Need for a team leader, capacity development for project staff and developing CHVs into trainers	i. Supervision and guidance of field staff ii. Dedicated person for project management	New team leader appointed who developed the current plan but left the job soon after. This resulted in gap in detailed planning and implementation. Field level supervision is lacking. Few CHVs occasionally help in training.
Need based programs for Paharia population	Evening schools run by local volunteer	Good intervention. Many others needs related to livelihood and health observed.
Strengthening SHGs and consolidating the achievements	No seed fund for SHGs Plan for accessing government schemes and networking.	Current staffs are not able to keep up with the needs of the SHGs. Linkage to government programs not in planned manner
Networking and collaborative work in health and IGP with government health system, government development programs and other NGOs.	Many specific plans Plan to bring RD for IGP training input.	Most of networking plans not followed through due to lack of a strong leader. Current staffs lack confidence and communication skills. RD became a partner with substantial funding for providing all development related input except support for SHGs
Need for external experts for input in specific areas of project implementation and monitoring.	Inclusion of external experts in Project Management committee Engaging public health experts for periodic review of progress	None in any committee at present

Observations/ concerns/ recommendation in Phase II evaluation	How it is addressed in Phase III CBPHCP project document	Current status
Organize teams of experts from NELC membership to support radio programs related to health in developing programs, ensuring quality and feedback	Not addressed	RS feels competent to run program.

4.2 Other deficiencies still present:

i. Presence in the field- As mentioned before and confirmed by CHVs, the staffs spend very little time in the field as most of their time is spent in organizing trainings in MCH. Female staffs are not working independently cutting on another male staff's time further.
ii. No review and reassessment of specific areas- Out clinic (village clinic), CHVs' role, and strategy to improve reach of radio program etc.
iii. Financial provision for staff training for fulltime project staffs is not utilized.

5. SPECIFIC REMARKS FOR CONTINUING THE PROJECT FOR REMAINING PERIOD OF PHASE III-

i. Project team should take time to read the primary proposals, subsequent review documents, annual plans and progress reports. Then work on objective, which is SMART and aligned with the vision of CBPHCP.

ii. Each components need to be critically analyzed by the project team and decision to be made whether to continue or discontinue based on current needs and competency of the team and MCH. Budget to be revised accordingly.

iii. Detailed plan to be prepared for each component and process indicators to be identified along with impact indicator for the remaining period.

iv. Team leaders (coordinator and program officer) should monitor the input- output-outcome of each component against the expenditure.

v. Project management training is badly required for higher level functionaries. They should visit some good projects in Jharkhand.

vi. Team need to be mentored by external experts in addition to NELC and MCH leaders.

vii. For administrative and legal purpose medical superintendent of MCH is the principal project holder. But for operational purposes the project coordinator should be empowered to handle everything including budget, and accountability should be well defined with respective authority.

viii. CBPHCP Sunday as a Church wide celebration is recommended.

ix. Project staffs and MCH need to optimally utilize and be accountable for resources available through the project such as access to Internet, documentation using cameras, vehicles and two wheelers.

6.RECOMMENDATIONS:

6.1 MAIN CONSTRAINTS

1. Project is lacking alignment of overall vision, objectives and activities with specific indicators towards expected outcomes.

2. Roles of different levels of committees, hospital management board, MCH leadership, partners and project staff are unclear resulting in poor accountability.

3. Achievements against each objective are difficult to ascertain due to lack of data and an appropriate documentation system.

4. The context has changed with government health services improving and better governance through PRI. This is a challenge for all Christian hospitals due to limited funds and skilled persons needed to deliver services in a competitive setting. MCH and CBPHCP need to be relevant in this context as a competent player in provision of primary and higher level health services and for development action. CBPHCP team has not been able develop and maintain competency for responding to changing context and needs of the community.

5. There is a growing demand for professionalism and transparency in the work of NGO's in India. Current management systems and personnel in MCH are inadequate for this.

6.2 MAIN RECOMMENDATIONS-

1 Develop and maintain administrative and project management systems to support CBPHCP at Central coordination level, MCH level and project management level. Specific systems needed are good financial management, clear partner agreement, Monitoring and Evaluation system at project level and defined role of project management committee/ board.

2 Build competency of staff and project coordinator for project planning, implementation and management.

3 Modify the project proposal to align the inputs planned with outcome and impact, according to the original vision and objectives. Develop appropriate indicators and M&E system for it.

4 Redefine roles of partners to support field project staff and maximizing benefit to the community.

5 Put in place an external monitoring group (including the funding partner) to follow the progress.

6 Bring the congregations into the center-stage as equal partners involving them at each step to identify needs, develop plans, prioritize, develop appropriate strategies for intervention and monitor the project implementation.

7 Carry out studies to document the impact of SHGs and health input by the project till now.

6.3. RECOMMENDATIONS FOR THE FUNDING PARTNER

1 Mission office should send the proposal to appropriate consultant and get feedback on the design. As parent body it is good to show generosity and give freedom to the country projects in order to maintain relationships built over long time. But before approving the projects for long term funding getting some feedback on the quality of the proposal and the relevance of the input to get desired impact should be assessed. It would help in many ways.

2 Annual monitoring is seriously required to keep the team on track. Financial tracking should be done on quarterly basis. Progress report should capture the impact made against each indicator.

7. LEARNINGS AND CONCLUSION:

Health and development needs of a marginalized and vulnerable community are complex. Health professionals are little equipped to address the issues making it difficult for a health care organization like Mohulpahari Christian Hospital to respond without additional human resource competent in project management and working with community. There is also a specific need for building competency of the institutions (MCH & NELC) to implement projects and programs with legal and specific financial and administrative requirements.

MCH took this challenge to address varied needs of the surrounding population with improving health access and capacity building input. Over the last 10 years the context has changed with better health access and preventive care. Has the project and input by CHVs and women's groups contributed to this change? Impressions at the community definitely support this. Awareness of health and development issues, entitlements and programs is good in project villages. Presence of CHVs in community forum at congregations has changed the outlook towards care for women and children, about diseases and role of women.

Self help concept to organize women into groups and empowering them to take up social and economic activities is widely prevalent in India now. 10 years ago it was a new concept and government programs were not developed to meet the needs. CBPHCP bridged this gap and initiated the process in many communities. As mentioned before, the groups with good leaders have flourished and are confident women writing their own future. Many have not gone the standard route of grading and credit but are still successful because they have got their families out of the clutches of money lenders. There is a difference between the family of an SHG member and another without. They are aware, work in a team, have developed cooperative values, look for opportunities to move forward, demand and get respect from their families and community. Many are elected leaders in PRI. It speaks volumes about what organizing in group has done to them. Some of these changes are quantifiable while others need careful documentation. This is urgently needed.

Time is needed to communicate to marginalized communities that health, education, livelihood are their rights. They need time to learn how to take these RIGHTS. Different people and groups will do this at different pace and a time bound project is not able to allow for this. CBPHCP over many years has made it possible for MCH and communities to learn about their place and role in this fast changing society. Generous funding for projects like CBPHCP are necessary to allow the needed time and space for such changes to happen, and the role of funding partner in this is commendable.

"Encouraging the hospital staff to be Spirit-filled workers in their Church; workers so faithful that they will assist in the smaller tasks of the local Church, and yet so far seeing that they will envision the distant fields that are white unto harvest"

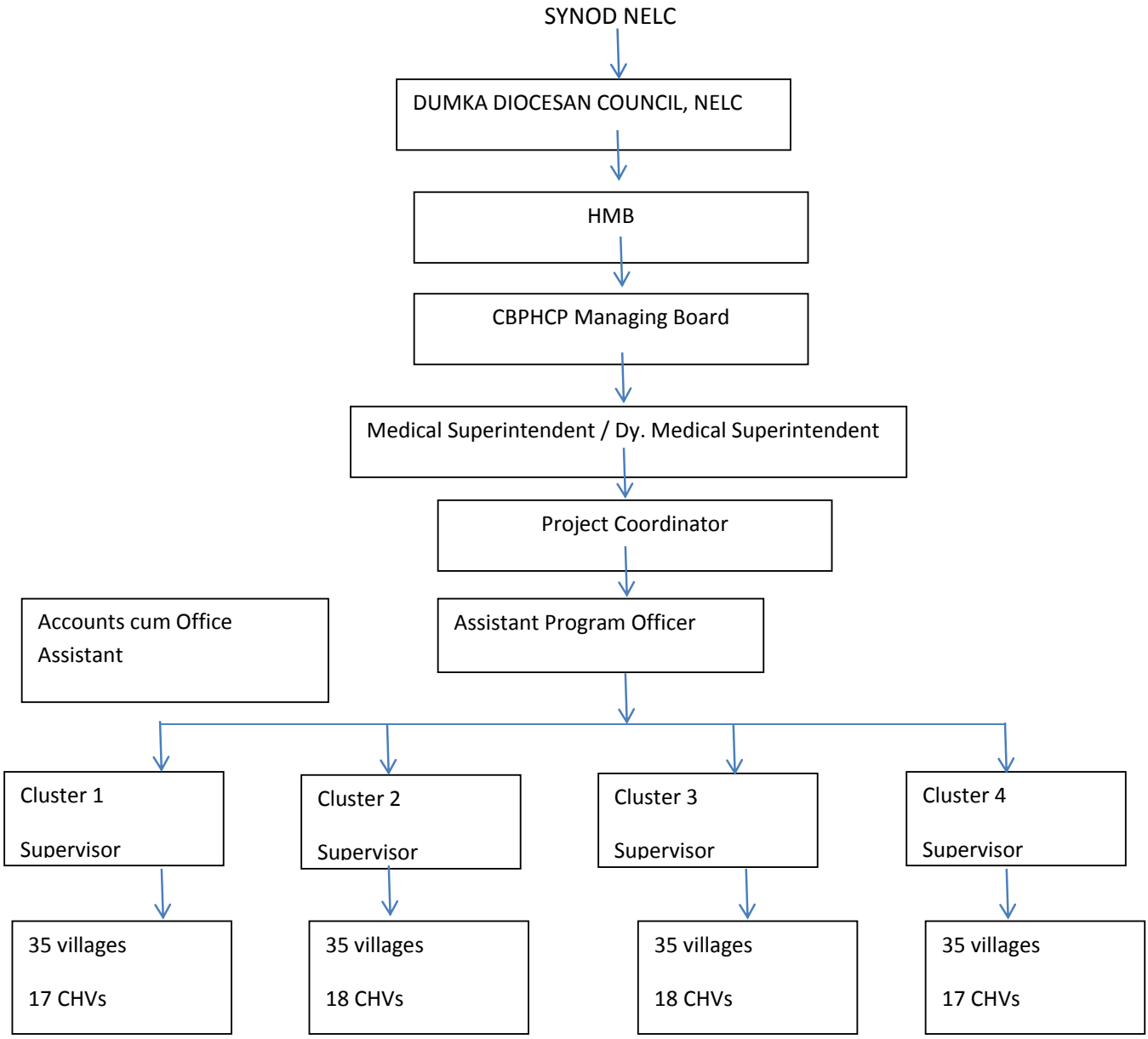
These were words written by Alice Axelson, HilmaGjerde, Kristofer Hagen and Bertha Hagen when the plans for moving the hospital from Bengaria to Mohulpahari were made in 1949. MCH has been faithful in seeing far beyond the medical care model; challenging themselves as a healing community, partners within NELC, NELC as a church, Normisjon and all others who come in contact with this mission. While the response from all the players is formed and implemented, the need is to focus on the ***FIELD*** (the people, community, and congregations), the ***HARVEST*** (input linked to outcome and Impact) and the ***WORKERS*** (staff and congregations). So that when harvest is done, there will be "***FULLNESS of LIFE***".

The questions still need answering are these-
Who is the Nehemiah to rebuild the wall?
Who is the Moses to redeem the people?
Who is the Ezra to bring the revival?
Who is the Isaiah to predict the fall and captivity?

There is a need for leaders, visionaries, risk takers, dedicated workers and monitors; a challenge for all involved in CBPHCP to realize the vision.

ANNEXURE 1

CBPHCP Organogram (as in Project Document)



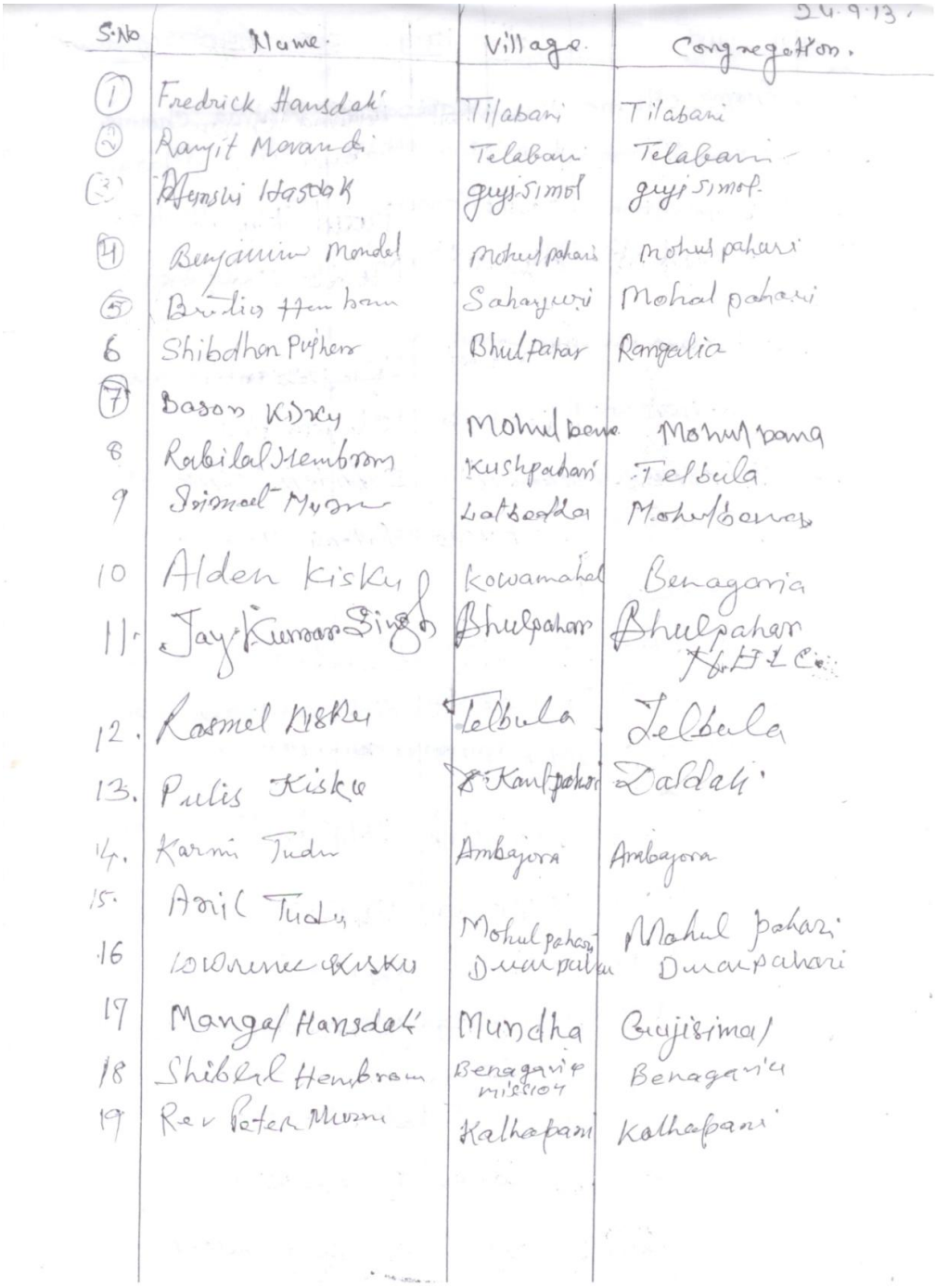
ANNEXURE 2

List of organizations and hospitals recommended for staff training

1. Navjeevan Hospital, Satbarwa can expose to livelihood initiatives and developing LFA based planning
2. EHA hospital in Madhipura has agriculture project. Exposure will give ideas and the person in-charge can be requested to help plan livelihood component of the project.
3. EFFICOR's training on Community Transformation will help the congregations. They continue with follow-up. Email sent to Mr. Green by Mr. Antony Samy (1st Oct)
4. "Sahyog" an EHA initiative based in Delhi can help with advocacy work. Mr. Mark Delany can be requested to run a workshop for NELC group and trainers. Local advocate currently involved with CBPHCP is a dynamic person and will be able to help plan the advocacy effort.
5. Facilitation and community organization is a basic skill needed for all staff. All need to do this.
6. Few staff can be trained on PRA by PRAXIS (Patna) to become trainers and facilitators and use methods for participatory project planning and monitoring. www.praxisindia.org – Patna- 1st Floor, Maa Sharde Complex, East Boring Canal Road. Patna 800001. Phone 09431017711, 06122521983
7. Accountant needs support to manage the system.
8. Links made with EFFICOR's Pakur team- Good M&E system

ANNEXURE 3

List of participants (CHV/ Congregation members, Pastor) who attended stakeholder workshop on 24th September 2013. Photographs and report.

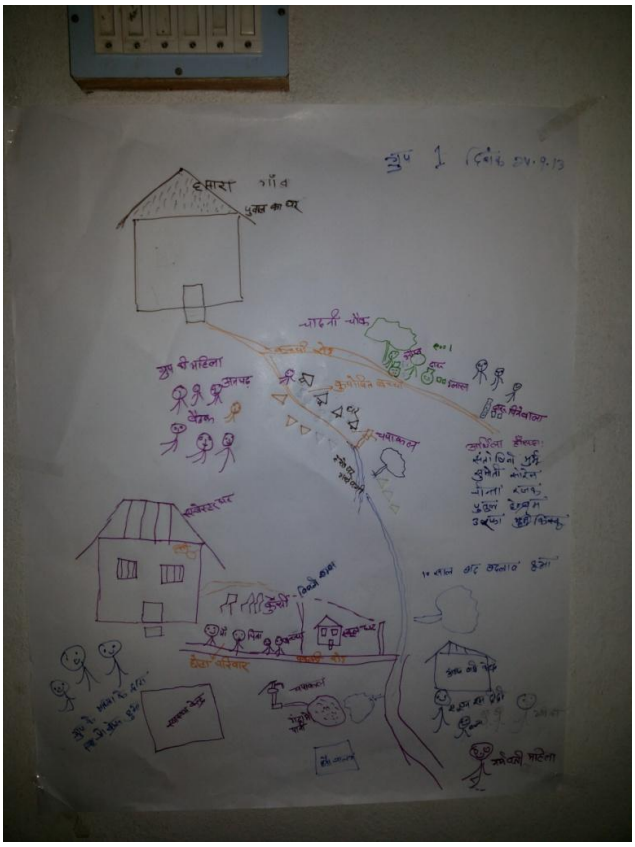


S.No	Name	Village	Congregation
1	Fredrick Hansdak	Tilabani	Tilabani
2	Ranjit Marandi	Telabani	Telabani
3	Ajenshi Hasdak	gujisimol	gujisimol
4	Benjamin Mondal	Mohulpahari	mohulpahari
5	Bindia Hembram	Sahajuri	Mohal pahari
6	Shibdhan Pathers	Bhulpahar	Rangalia
7	Bason Kisku	Mohulbana	Mohulpana
8	Rabilal Hembram	Kushpahari	Telbula
9	Ismael Murmu	Lalsodda	Mohulbana
10	Alden Kisku	kowamahal	Benagaria
11	Jay Kumar Singh	Bhulpahar	Bhulpahar KHLC
12	Kasmel Kisku	Telbula	Telbula
13	Pulis Kisku	Kushpahari	Daldali
14	Karmi Tudu	Ambajora	Ambajora
15	Anil Tudu	Mohulpahari	Mahul pahari
16	Lorence Kisku	Duarpahar	Duarpahari
17	Manga Hansdak	Mundha	Gujisimal
18	Shibkal Hembram	Benagaria mission	Benagaria
19	Rev Peter Murmu	Kalhapani	Kalhapani

	नाम	गाँव	~~Sign~~ Signature
1.	Anima Chonre	Kantpahari	Anima Chonre
2.	Sabina Marandi	Duarpahari	Sabina Marandi
3.			
4.	Putul Hembrom	Kadma	Putul Hembrom
5.	Merila Hansdak	Aligonj	Merila Hansdak
6.	~~Detildi~~ murmu	Ramdani	~~Detildi~~ murmurmu
7.	Chinta Rajan	Pokhuica	Chinta Rajan
8.	Subhasini Marandi	simlidi	Subhasini Marandi
9.	Salomi Tudu	Darbarpur	Salomi Tudu
10	~~Pu~~ Puspalata Saren	Siroadih	puspalata saren
11	Subasini. Soren	Bongaria	Subasini. Soren
12	Bharti Tudu	Murayaru	Bharti Tudu.
13	Ruth Tudu	Citadih	Ruth Tudu
14	Somoti Soren	Kalhapani	Somoti Soren
15	priskila soren	Kalhajhar	priskila soren
16.	Arthila Hansdak	Bongaria	Arthila Hansdak

16.	Arthila Hansdak	Beragaria	Arthila Hansdak
17	Dina Soren	chiropatha	Dina Soren
18	Santoshini Murmu	Shintall	Santoshini Murmu
19	Poulina Kisku	Mohulbona	Poulina Kisku
20	Stenshila Hansdak	Saltoda	Stenshila Hansdak
21	निर्मोती हेंसदा	कुराघाड़ी	निर्मोती हेंसदा
22	सुशीला हेंसदा	सिमलती	सुशीला हेंसदा
23	पुतुल मुर्मू	बरमसिमा	Putul murmu
24.	इरला किस्कू	पुतापुर	इरला किस्कू
25	मगदालिनी हेम्ब्रम	काली-पुंजा	मगदालिनी हेम्ब्रम

Visioning exercise findings (CHV) and photographs-



Women organized in groups

Better infra-structure, water, housing

Small families

Getting rid of alcohol problem

Figure 1

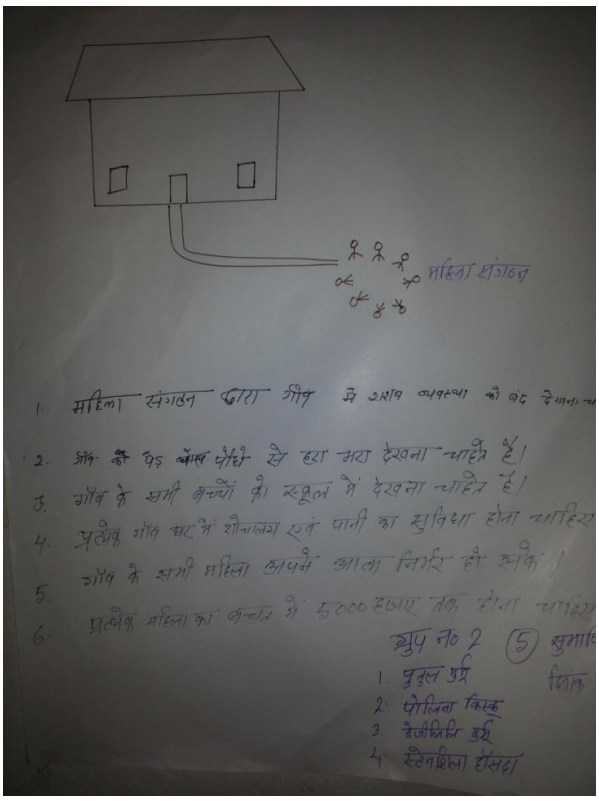


Figure 2

Stop alcohol sale through SHG effort

Increase green cover

All children in school

All houses with water and toilets

Every woman should be self sufficient

Every woman should have Rs. 5000 saving

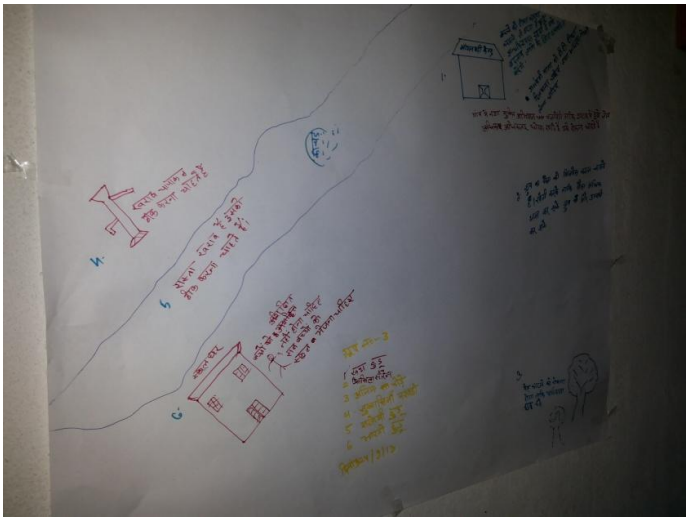
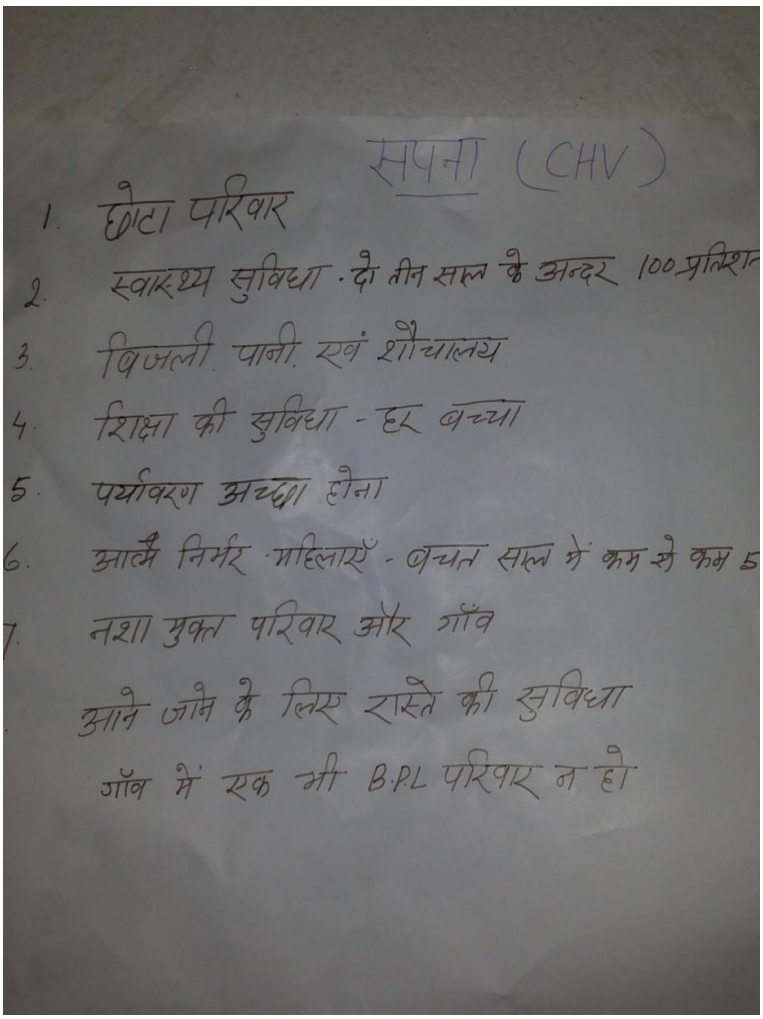


Figure 3



Dream (Summarized from 4 charts by CHVs)

1. Small family
2. 100% Health access within 2-3 years
3. Electricity, water and toilets
4. Every child to have opportunity for schooling
5. Better environment
6. Self reliant women –savings Rs. 5000 in a year per person
7. Family and community free of alcohol
8. Roads
9. No BPL (below

Figure 4

Game- group dynamics 1

Group work 1

Group work 2

CHV's assessment of project performance and Visioning exercise-

24th Sept- MCH-CBPHCP conference room

CHVs with More than 5yrs in Project-

Improvement needed-

- Improve development component
- Remove poverty

Good –

- Care for women and children improved
- Sick can get referred to MCH
- Tree planting
- Improvement in hygiene
- SHG members trained

New CHVs < 2 years in the project

Improvement needed-

- Better time management
- Supervisors should give more time in the villages
- Travel difficult for CHVs

Good-

- Referral facility for poor, concessional care at MCH
- Improved care for mother and child
- Training of villagers and SHG members
- Preaching of gospel by recording studio
- Training and agriculture input by RD

Assessment of participation of different stakeholders in the project- CHV perspective

Newer group (independently done)-

25% - MCH, MS and deputy MS

25%- Coordinator and program officer

5% - Community Member

Dreaming session (10 year from now)

1. Small families
2. Health access 100% within 2-3 years
3. Water, toilets and Electricity
4. Every child should have access to education
5. Good eco-system
6. Financially self-reliant women- (Indicator- savings Rs. 5000/- per year)
7. Alcohol free family and community
8. Road infra-structure
9. No BPL family in the village

Some activities identified -

3. Hand pump repair
5. Stop cutting trees
6. Improve income of SHGs- small business, home based
7. Movement against alcohol sale/use, form SHGs of women involved in alcohol sale

Learnings from participatory problem analysis and visioning exercise
24th September 2013

Venue- Mohulpahari Church

Participants- Congregation leaders/ Pastors/ Evangelists (hap'ram)

Facilitator – Mr. Antony Samy

Vision for Society that is

1. Alcohol free
2. Peace loving
3. Educated
4. Free of diseases
5. Unity
6. No jealousy
7. Good behavior/ relationship/ clean relationships
8. Superstition free
9. Spiritual revival
10. Free from poverty
11. Better nutrition

12. Better agricultural
13. Aware of health issues
14. Helpful to others
15. Happiness
16. Truthful society
17. Maintain tradition

Problems identified -

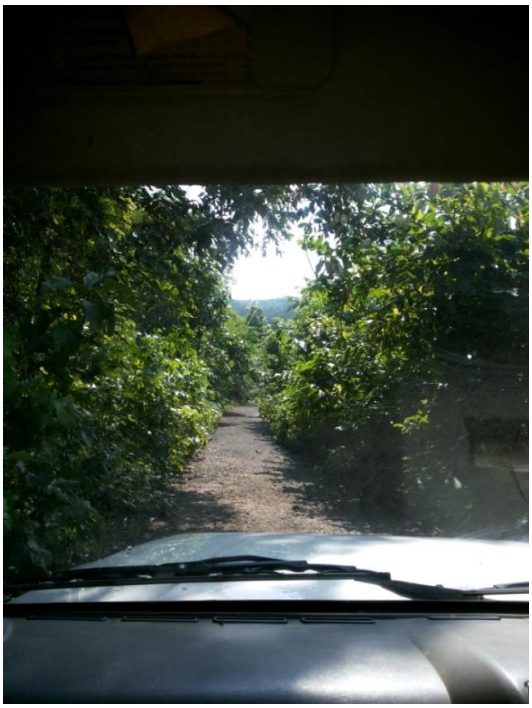
1. Lack of peace
2. Stealing, fighting
3. Alcoholism
4. Migration
5. Discrimination
6. Lack of Unity
7. Illicit relationships
8. Lack of good agricultural practices
9. Lack of water
10. Poor roads- difficulty in transportation
11. Mental health issues
12. Laziness
13. Poor time management
14. Society problem
15. Lack of nutritious food
16. Lack of safe water
17. Deforestation
18. Poor hygiene
19. Lack of timely health care

Reasons:

1. Poor education
2. Poverty
3. Diseases
4. Poor understanding
5. Peer pressure

Annexure 4

Photographs from Site visit



Way to Mal-Paharia village Chhatupara- approximately 9 km of forest

Photograph 1

Dynamic and progressive SHG- Leader in Blue sari

Photograph 2

Collective farming- Sagen Baha SHG, Kesorgarh

Photograph 3

Photograph 4

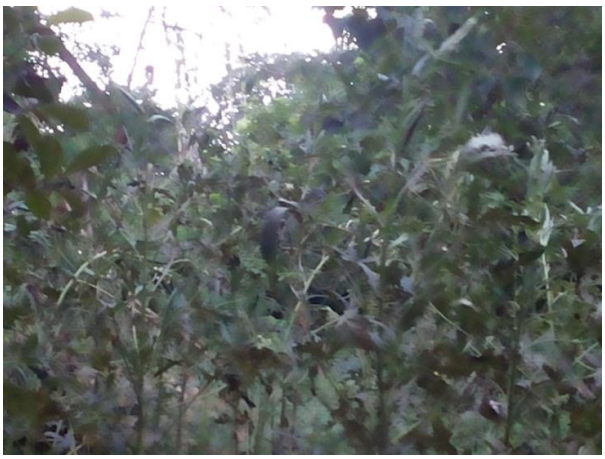
Dynamic, inspiring Mal-Paharia volunteer- Mr. Durga Dehri with wife. Believer, witness and leader though physically challenged

Photograph 5

Photograph 6

High yield of vegetable crops and fast growth of tree with charcoal use.

Photograph 7



Photograph 8

Dynamic traditional woman leader. No work in village because there is no CHV. Practices bio-based farm inputs

Photograph 9